DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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PRINTED: 12/19/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445136	A. BUILDING _____ B. WING _____	12/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED NURSING AND REHABILITATION-MASTERS	278 DRY VALLEY RD ALGOOD, TN 38501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification and complaint investigation (#32677, #32825, #32876, and #32959) survey was conducted from December 9, through December 11, 2013, at Kindred Nursing and Rehabilitation - Masters. No deficiencies were cited related to the complaint investigations (#32677, #32876, and #32959) under 42 CFR Part 483.13, Requirements for Long Term Care Facilities.	F 000	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, facility policy review, and interview, the facility failed to provide the call light within reach for one resident (#122) of thirty-five residents reviewed. The findings included: Resident #122 was admitted to the facility on March 23, 2012, with diagnoses including Coronary Artery Disease, Dysphagia, Hypertension, and Hemiplegia. Medical record review of the Quarterly Minimum Data Set (MDS) dated November 7, 2013,	F 246	F246 It is the practice of this facility to provide call lights within residents reach. Resident #122 re-assessed for proper placement of call light when resident is in bed or up in wheelchair. Care plan updated to address location of call light. When resident out of bed call light to be placed across bed within reach of resident, in bed call light to be placed on right side on side rail with clip attached some call bottom upside. Residents residing in the facility were assessed for proper placement of call light by DNS and Charge Nurses over their wing on 12/11/13. Licensed nurses & certified nursing assistants will be in-serviced on facility policy on positioning of call lights by Dec 31, 2013 by DNS/ADNS/SDC RN Supervisor. Meetings scheduled for 12/23/13, 12/24/14, 12/27/13 and 12/31/13. This information will also be included in new hire orientation. DNS/ADNS/SDC/RN Supervisor will make rounds 3-5 times a week to monitor placement of call lights. At anytime call lights observed not in proper position nursing staff will be re-in serviced with disciplinary action carried out by DNS/ADNS or RN Supervisor.	12/31/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sylvia J. Burton
TITLE: Executive Director
(X6) DATE: 12/31/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 246	Continued From page 1 revealed the resident scored 15 out of 15 on the Brief Interview for Mental Status, indicating the resident was cognitively intact. Continued MDS review revealed the resident required extensive assistance of two persons for bed mobility and transfers, and extensive assistance of one person for dressing. Continued review of the MDS revealed the resident had functional range of motion limitation on one side for upper and lower extremities. Observation in the resident's room on December 10, 2013, at 4:10 p.m., revealed the resident's call light was attached to the right upper side rail on the resident's bed, and the resident was up in a wheelchair on the left side of the bed. Continued observation revealed the resident asked if the call light could be placed within reach. Continued observation revealed the family member of the resident's roommate repositioned the call light for the resident, and placed it within reach. Observation in the resident's room on December 11, 2013, at 4:55 a.m., revealed the resident lying on the bed with bilateral upper side rails raised. Continued observation revealed the resident's call light was wrapped around the right side rail with the call-button near the floor. Continued observation revealed the resident unsuccessfully attempted to access the call light by pulling on the cord. Review of the facility's policy, Call Light, Use of, revealed, "...Position the call light within reach of the resident..." Interview on December 11, 2013, at 5:30 a.m., with the Unit Manager at the nurse's station (C/D wing), confirmed the call lights should be within	F 246	These rounds by DNS/ADNS/SDC and/or RN Supervisor will continue weekly X4 weeks or until compliance achieved and then monthly by RN Supervisor on 5 room per wing. Results of the weekly audit & monthly rounds will be reported to the facility performance improvement committee (DNS/ADNS, ED, Case manager, AC, maintenance supervisor, SDC, dietician, Medical Director, Activities, & MDS Coordinator) by the DNS for review, discussion and recommendations.	

Sylvia J. Burton 12/31/13

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F 246	Continued From page 2 the resident's reach at all times.	F 246		
F 258 SS=D	483.15(h)(7) MAINTENANCE OF COMFORTABLE SOUND LEVELS The facility must provide for the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on interview and observation, the facility failed to maintain a comfortable sound level on th e A Wing. The findings included: Interview on December 9, 2013, at 2:34 p.m., in the resident's room on the A Wing, with Resident #1 25, revealed the wheels on the carts and barrels used by laundry and the meal delivery ca rts "make a loud racket" as they roll across the A Wing nursing station area floor. Further interview revealed the resident requested a room change to be further away from the area which was honored. Observation and Interview on December 10, 2013, at 9:42 a.m., at the A Wing nursing station revealed laundry barrels, dietary tray delivery carts, and utility carts passing the nursing station. Further observation revealed the carts made a great deal of noise as they rolled over the floor tiles. Interview with Licensed Practical Nurse #4 confirmed the carts were very noisy as they rolled across the floor making conversation difficult.	F 258	F258-Maintenance of Comfortable Sound Levels Staff moving carts and barrels in serviced by individual department heads to slow down when crossing the ceramic tile with carts and barrels. This has reduced the noise level. All carts will be evaluated by maintenance to see if quieter wheels are available. Weekly social services will check the residents in room 100, 101, 200 for concerns. Results will be reviewed at the performance improvement meeting.	12/31/13
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280		

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F 280	Continued From page 3 The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to revise the care plan to reflect changes in resident status for two (#98, #214) of thirty-five residents reviewed. The findings included: Resident #98 was admitted to the facility on December 26, 2011, with diagnoses including Dementia, Atherosclerotic Cardiovascular Disease, Coronary Artery Bypass Graft, Congestive Heart Failure, Anemia, Osteoporosis, Peripheral Vascular Disease, Hypertension, and Cellulitis.	F 280	F280 It is the practice of this facility to revise the care plan to reflect changes in the resident's status. Resident #98 care plan has been reviewed and revised to reflect resident's current status. Resident #214 care plan has been reviewed and revised to reflect resident's current status. Residents having potential to be affected by the deficient practice will be identify by reviewing physicians order for the last quarter as well as review of the clinical rounds documentation. This will be complete by December 31, 2013 by the DNS and MDS Coordinator. Any residents with care plan not revised to reflect change of status will be updated at this time. Systematic changes to ensure deficient practice does not recur include reviewing all physicians' orders daily with the clinical team and updating care plans, when indicated. Care plans will be checked during clinical rounds to validate care plan were updated. At any time care plans are not revised, in-service will be done with nurse who failed to update. Licensed nurses will be in-serviced on expectations of care planning, reviewing and revising as needed by DNS, SDC, ADNS, MDS coordinator and RN supervisors by December 31, 2013. This in-service information will be added to new hire orientation. Meeting scheduled for 12/23/13, 12/24/13, 12/27/13 and 12/30/13. The results of clinical rounds will be reported to the performance improvement committee by MDS Coordinator for review, discussion and recommendation.	1/1/14

Sylvia J. Bustm 12/31/13

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F 280	Continued From page 4 Medical record review of a nursing assessment dated October 19, 2013, revealed the resident had a Brief Interview of Mental Status of 4/15, indicating severe cognitive impairment; required extensive assistance with bathing, dressing, grooming, and transfers. Continued review of the nursing assessment revealed the resident needed to be fed; was incontinent of bowel and bladder; resisted care; and cursed, yelled, and ran into other residents with the wheelchair. Medical record review of the care plan revised on September 29, 2013, revealed a focus of "...Actual alteration in skin integrity r/t (related to) redness to bottom, venous ulcer to left outer ankle..." Medical record review of physicians' orders dated April 20, 2013, revealed an order for "...skin prep to bilateral heels and ankles BID (twice daily) and prn (as needed)..." Medical record review of the care plan revealed the care plan was not revised to reflect this order as an intervention. Medical record review of physicians' orders dated October 10, 2013, revealed an order to "...apply Santyl (debrider to remove necrotic tissue) and dry dressing to left outer ankle daily and prn..." Medical record review of the care plan revealed the care plan was not revised to reflect this order as an intervention. Medical record review of physicians' orders dated November 1, 2013, revealed an order to "...apply layer of Baza cream followed by layer of nystatin	F 280		

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F 280	Continued From page 5 cream then layer of triamcinolone cream to buttocks each shift..." Medical record review of the care plan revealed the care plan was not revised to include this order as an intervention. Interview with the Director of Nursing on December 11, 2013, at 3:55 p.m. in the dining room, confirmed the three orders by the physician had not been incorporated into the care plan as current interventions. COMPLAINT #32825 Resident #214 was admitted to the facility on September 23, 2013, with diagnoses including Chronic Airway Obstruction, Diabetes, Hypertension, Dementia with Behavioral Disturbance, Depressive Disorder, Anxiety, and Insomnia. Medical record review of the Admission Minimum Data Set (MDS) dated September 30, 2013, did not include Acute Cystitis (bladder infection) as a diagnosis. Review of the Significant Change MDS dated November 15, 2013, revealed the resident had Acute Cystitis added as a diagnosis. Medical record review of the resident's Care Plan initiated September 23, and updated November 18, 2013, revealed the Care Plan did not address the treatment interventions for the resident's Acute Cystitis. Further review of the medical record revealed on November 6, 2013, the physician ordered Macrobid 100 mg. every 12 hours for 10 days for Acute Cystitis.	F 280		

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F 280	Continued From page 6 Interview with Registered Nurse Supervisor #1 on December 10, 2013, at 3:55 p.m., in the G Wing nurse's station, confirmed the Care Plan had not been updated to include the interventions for the Acute Cystitis.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to document treatments consistently on a resident who was medically compromised for one (#98) of thirty-five residents reviewed. The findings included: Resident #98 was admitted to the facility on December 26, 2011, with diagnoses including Dementia, Atherosclerotic Cardiovascular Disease, Coronary Artery Bypass Graft, Congestive Heart Failure, Anemia, Osteoporos Peripheral Vascular Disease, Hypertension, an Cellulitis. Medical record review of a nursing assessment dated October 19, 2013, revealed the resident had a Brief Interview for Mental Status of 4/15, indicating severe cognitive impairment; required extensive assistance with bathing, dressing, grooming, and transfers. Continued medical record review revealed the resident needed to be	F 281	F281 It is the practice of this facility to document treatments consistently on residents who are medically comprised. Resident #98 has been re-assessed to ensure appropriate skin care is being documented on treatment record to reflect current status. Care plan updated to address skin care issues. Treatment sheets reviewed by skin care coordinator on 11/16/13. Residents residing in facility had treatment sheets reviewed to ensure correct treatments were being done as ordered by physician by skin care coordinator and Charge nurses on wings by December 31, 2013. Licensed nurses to be in serviced on consistent documentation of treatment records by DNS/ADNS/SDC/RN Supervisor. Meeting scheduled for 12/23/13, 12/24/13, 12/27/13, and 12/30/13. This in-service information will be added to the new hire orientation. DNS/ADNS/SDC/RN Supervisor will audit treatment records 2-3 times a week to ensure consistent compliance with treatment records. These audits will continue weekly X4 weeks or until compliance achieved and then routine monthly audits during clinical rounds by RN Supervisor. The results of the weekly & monthly audits will be reported to performance improvement committee by DNS for review discussion & recommendation.	1/1/14

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F 281	Continued From page 7 fed; was incontinent of bowel and bladder; resisted care; and cursed, yelled, and ran into other residents with the wheelchair. Medical record review of the Weekly Skin Assessment dated November 19, 2013, revealed the resident had an ulcer on the left lateral ankle related to venous insufficiency, which measured 3.9 cm (centimeters) x 3.6 cm x 0.3 cm, and was a "...black wound with red macerated tissue surrounding..." Medical record review of physician's orders dated April 20, 2013, revealed an order for "...skin prep to bilateral heels and ankles twice daily and as needed..." Continued review of physicians' orders dated October 10, 2013, revealed an order for "...Apply Santyl (remove necrotic tissue) and dry dressing to left outer ankle daily and as needed..." Further review of physicians' orders dated November 1, 2013, revealed an order for "...Apply a layer of Baza cream then a layer of nystatin cream then a layer of triamcinolone cream to buttocks each shift..." Medical record review of the Treatment Record for November 2013, revealed the application of creams not documented as applied on November 5, 6, 12, 18, 22, 25, 28, and 30, 2013 on the 6:00 p.m. - 6:00 a.m. shift, and on November 20 and 26, 2013, on the 6:00 a.m. - 6:00 p.m. shift. Continued review of the Treatment Record for October 2013, revealed the application of creams was not documented as applied on October 2, 7, 9, 12, 14, 15, 16, 18, 19, and 30, 2013 on the 6:00 p.m. - 6:00 a.m. shift, and October 11, 26, 28, and 30, 2013, on the 6:00 a.m. - 6:00 p.m. shift.	F 281		

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F 281	Continued From page 8 Medical record review of the Treatment Record for November 2013, revealed the application of s kin prep to bilateral heels was not documented a.s completed on November 5, 6, 12, 18, 28, 29, and 30, 2013, on the 6:00 p.m. - 6:00 a.m. shift, and November 20 and 26, 2013, on the 6:00 a.m. - 6:00 p.m. shift. Continued review of the Treatment Record for October 2013, revealed the application of skin prep to the heels was not documented on October 2, 7, 9, 12, 14, 15, 18, and 30, 2013, on the 6:00 p.m. - 6:00 a.m. shift, and October 11, 28, and 30, 2013, on the 6:00 a. m. - 6:00 p.m. shift. Medical record review of Weekly Skin Assessments for October and November 2013, revealed the perineal excoriation had improved from being reddish-purple to purple and had no further raised areas. Interview with the Director of Nursing on December 11, 2013, at 2:50 p.m., in the dining room, confirmed there were many times when treatments of application of skin prep to both feet and ankles and application of creams to buttocks were not documented so there was no way to know if the treatments had actually been completed as ordered.	F 281		
F 312 SS=D	COMPLAINT #32825 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312		

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F 312	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to document activities of daily living consistently for a resident who required extensive assistance for one (#98) of thirty-five residents reviewed. The findings included: Resident #98 was admitted to the facility on December 26, 2011, with diagnoses including Dementia, Atherosclerotic Cardiovascular Disease, Coronary Artery Bypass Graft, Congestive Heart Failure, Anemia, Osteoporosis, Peripheral Vascular Disease, Hypertension, and Cellulitis. Medical record review of a nursing assessment dated October 19, 2013, revealed the resident had a Brief Interview for Mental Status of 4/15, indicating severe cognitive impairment; required extensive assistance with bathing, dressing, grooming, and transfers. Continued medical record review revealed the resident needed to be fed; was incontinent of bowel and bladder; resisted care; and cursed, yelled, and ran into other residents with the wheelchair. Medical record review of the Flow Sheet Record used by the Certified Nursing Assistants (CNA), revealed "...Shower 2x/wk (two times a week), Bedbath all other days..." Continued review of the Flow Sheet Record for November 2013, revealed no documentation the resident received a bedbath on November 4, 5, 6, 8, 11, 17, 18, 19, 20, 22, 27, and 31, 2013. Further review of the	F 312	F312 It is the practice of this facility to document activities of daily living consistently for residents who required extensive assistance. Resident #98 was re-assessed by DNS to ensure resident is receiving care with appropriate documentation to address activities of daily living. Resident to receive showers 2 times week with bed baths between showers. If a resident refuses bed bath staff will document reason and notify family. Residents residing in the facility flow sheets reviewed by DNS/ADNS on 12/16/13. Licensed nurses and certified nursing assistance will be in serviced by DNS/ADNS/SDC/RN Supervisor to address the lack of documentation with activities of daily living to include bathing by Dec 31, 2013. This in-service information will be added to new hire orientation. Meeting scheduled for 12/23/13, 12/24/13, 12/27/13 and 12/30/13. Systematic changes to ensure deficient practice does not reoccur include audit of flow sheet records by DNS/ADNS/SDC/RN Supervisor 2-3 times week. These audits will continue weekly X4 weeks or until compliance achieved & then monthly during clinical rounds by RN Supervisor. The results of the audit will be reported to the facility performance improvement committee by DBS for review, discussion & recommendations.	1/1/14

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F 312	Continued From page 10 Flow Sheet Record revealed no documentation the resident received a bed bath on October 2, 3, 4, 6, 7, 8, 9, 11, 12, 13, 14, 16, 20, 21, 25, 26, 27, 28, and 30, 2013. Interview with the Director of Nursing on December 11, 2013, at 2:50 p.m., in the dining room, confirmed there were many occasions in which there was no documentation the resident was given a bedbath on days when a shower was not given and confirmed there was no way to determine if those bedbaths were given or not.	F 312		
F 463 SS=D	COMPLAINT #32825 483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the resident bathroom call light. The findings included: Observation and interview, on December 9, 2013, at 3:42 p.m., in the bathroom used by Resident #58, revealed the emergency call light had no string attached to facilitate activation. Interview, in the bathroom used by Resident #58, with Certified Nurse Aide #1, confirmed the resident self ambulated to the bathroom and could independently use the facility. Further interview	F 463	F-463 Resident Call System- Room/Toilet/Bath A complete inspection of call light system was completed on 12/11/13 by the maintenance department. Resident #58's call light was repaired as soon as maintenance was made aware. Maintenance will continue to conduct monthly Call System checks including all emergency stations for proper operation. Extra Call System supplies (call cords and string for emergency station) are placed in the Medication Rooms at each station for after hour replacement/ repairs by nursing staff. Staff has been in-serviced to check the call light stations each day as they are in the rooms assisting the resident's needs. They are to report any issues to the maintenance staff immediately.	1/1/14

Sylvia J. Burton 12/31/13

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445136	A. BUILDING _____ B. WING _____	12/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED NURSING AND REHABILITATION-MASTERS	278 DRY VALLEY RD ALGOOD, TN 38501

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F 463	Continued From page 11 confirmed the emergency call light did not have a string to facilitate activation. Interview on December 9, 2013, at 3:35 p.m., with the Assistant Director of Nursing, in the bathroom used by Resident #58, confirmed the emergency call light was to have a string to facilitate activation.	F 463		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to maintain a complete and accurate medical record for for one resident (#98) of thirty-five residents reviewed. The findings included: Resident #98 was admitted to the facility on December 26, 2011, with diagnoses including Dementia, Atherosclerotic Cardiovascular	F 514	F514 It is the practice of this facility to maintain a complete & accurate medical record for our residents. Resident #98 has been re-assessed, medical records reviewed by skin care coordinator and DNS on 12/16/13. Care plan updated to reflect resident's current status. Treatment records and Flow sheet records of residents residing in facility reviewed by charge nurses to reflect current status and complete documentation by December 31, 2013. Licensed Nurses and certified nursing assistants to be in-serviced on complete documentation to include treatments and bathing by DNS/ADNS/SDC/RN Supervisor by DEC 31, 2013. This in-service information will be added to the new hire orientation. Meeting scheduled for 12/23/13, 12/24/13, 12/27/13 and 12/30/13. DNS/ADNS/SDC/RN Supervisor will audit treatment records & flow sheet records 2-3 times week to ensure compliance with medical records. These audits will continue weekly X4 weeks or until compliance achieved, and monthly audits during clinical rounds by RN Supervisor. The results will be reported to facility performance improvement committee by DNS for review with recommendations.	1/1/14

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F 514	Continued From page 12 Disease, Coronary Artery Bypass Graft, Congestive Heart Failure, Anemia, Osteoporosis, Peripheral Vascular Disease, Hypertension, and Cellulitis. Medical record review of physician's orders dated April 20, 2013, revealed an order for "...skin prep to bilateral heels and ankles twice daily and as needed..." Continued review of physicians' orders dated October 10, 2013, revealed an order for "...Apply Santyl (remove necrotic tissue) and dry dressing to left outer ankle daily and as needed..." Further review of physicians' orders dated November 1, 2013, revealed an order for "...Apply a layer of Baza cream then a layer of nystatin cream then a layer of triamcinolone cream to buttocks each shift..." Medical record review of the Treatment Record for November 2013, revealed no documentation of the application of the creams as ordered, on November 5, 6, 12, 18, 22, 25, 28, and 30, 2013 on the 6:00 p.m. - 6:00 a.m. shift, and on November 20 and 26, 2013, on the 6:00 a.m. - 6:00 p.m. shift. Continued review of the Treatment Record for October 2013, revealed no documentation of the application of creams as ordered, on October 2, 7, 9, 12, 14, 15, 16, 18, 19, and 30, 2013 on the 6:00 p.m. - 6:00 a.m. shift, and October 11, 26, 28, and 30, 2013, on the 6:00 a.m. - 6:00 p.m. shift. Medical record review of the Treatment Record for November 2013, revealed no documentation of the application of skin prep to the heels as ordered on November 5, 6, 12, 18, 28, 29, and 30, 2013, on the 6:00 p.m. - 6:00 a.m. shift, and November 20 and 26, 2013, on the 6:00 a.m. - 6:00 p.m. shift. Continued review of the	F 514		

Sylvia J. Burton 12/31/14

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445138	A. BUILDING _____ B. WING _____	12/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED NURSING AND REHABILITATION-MASTERS	278 DRY VALLEY RD ALGOOD, TN 38501

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F 514	Continued From page 13 Treatment Record for October 2013, revealed no documentation of the application of skin prep to the heels as ordered on October 2, 7, 9, 12, 14, 15, 18, and 30, 2013, on the 6:00 p.m. - 6:00 a.m. shift, and October 11, 28, and 30, 2013, on the 6:00 a.m. - 6:00 p.m. shift. Medical record review of the Flow Sheet Record used by the Certified Nursing Assistants (CNA), revealed "...Shower 2x/wk (two times a week), Bedbath all other days..." Continued review of the Flow Sheet Record for November 2013, revealed no documentation the resident received a bedbath on November 4, 5, 6, 8, 11, 17, 18, 19, 20, 22, 27, and 31, 2013. Further review of the Flow Sheet Record revealed no documentation the resident received a bed bath on October 2, 3, 4, 6, 7, 8, 9, 11, 12, 13, 14, 16, 20, 21, 25, 26, 27, 28, and 30, 2013. Interview with the Director of Nursing on December 11, 2013, at 2:50 p.m., in the dining room, confirmed there were many occasions in which there was no documentation the resident was given a bedbath on days when a shower was not given and confirmed there was no way to determine if those bedbaths were given or not. Continued interview with the DON confirmed there were many times when treatments of application of skin prep to both feet and ankles and application of creams to buttocks were not documented so there was no way to know if the treatments had actually been completed as ordered. Continued interview confirmed the facility failed to maintain a complete and accurate medical record. COMPLAINT #32825	F 514		

Sylvia J. Burton 12/31/13